MDR: M4-02-5054-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $182.52 for date of service, 03/21/02 per the updated Table of Disputed Services received on 04/15/03.

   b. The request was received on 08/19/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Example EOB(s) from other Carriers
   e. Letter of Medical Necessity dated 03/20/02
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/13/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/18/02. The insurance carrier did not respond to the provider's request for medical dispute resolution. A "No Carrier Information Found" sheet is reflected in Exhibit II.

3. Notice of Letter requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 09/10/02

   "…I respectfully submit to you 1) A position statement 2) a LMN 3) A copy of the 'D' codes and 4) three EOB's from other IC'S reimbursed correctly for the same services. The submitted documentation supports unfair and unreasonable reimbursement. I have tried to speak with this IC (my phone call went unreturned) as well as submitting a request for reconsideration attaching a copy of the 'D' codes and EOB's from 3 other IC's as well as one of their own EOB's on this IE in which

the same service/code was billed and reimbursement was made at our usual and customary/fair and reasonable. (see enclosed copy) The billed amount is $270.00 and should be reimbursed at our usual and customary or per the 'D' codes MAR for stimulator supplies which is $85.00 per unit/month or #85.00 [sic] X 3 = $255.00. According to the Medical Fee Guidelines effective April 1, 1996, Paragraph VI. of the General Instructions states that the insurance carrier will reimburse the lesser of the billed charge or the MAR. DME Ground Rules state a fair and reasonable amount is the same as in the original DME (D-Codes) Fee Schedule."

2. Respondent: No response statement found in dispute file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/21/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the updated Requestor's Table of Disputed Services received 04/15/03, the Requestor billed the Carrier $270.00 for services rendered on the date above.

4. Per the updated Requestor's Table of Disputed Services received 04/15/03, the Carrier paid the Requestor $72.48 for services rendered on the date above and denied reimbursement as "M-Reduced to Fair and Reasonable 360 ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE 'FAIR AND REASONABLE' AMOUNT FOR THIS GEOGRAPHICAL AREA.""

5. Per the updated Requestor's Table of Disputed Services received 04/15/03, the amount in dispute is $182.52 for services rendered on the date of service in dispute above.

6. The Carrier did not respond to the provider's request for dispute resolution.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/21/02	A4556	$270.00 (3 units/months)	$72.48	M, 360	$85.00	TWCC Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).; MFG Gen Inst (VI); DME GR (IX) (C)	Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall: 1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement; 2. explain and document the method it used to calculate the rate of pay, and apply this method consistently; 3. reference its method in the claim file; and 4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement." The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The Carrier has supplied no methodology. The Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of fair and reasonable. As the Requestor, the health care provider must provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (3) (g) (D). The provider indicates that they have billed for Interferential stimulator electrodes. Code A4556 indicates electrodes. The 1991 "D" codes indicate "stimulator supplies" were to be paid at $85.00 per month. Therefore, additional reimbursement of **$182.52** ($255.00 - $72.48 carrier reimbursement = $182.52) is recommended.
Totals		$270.00	$72.48				The Requestor **is** entitled to additional reimbursement of **$182.52**.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $182.52 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 16th day of April 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt